

C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-5747 FAX: (208) 364-1811

October 15, 2007

Mariana Leahu, Administrator Phillippi House 703 S Phillippi St Boise, ID 83705

Dear Ms. Rolea:

On October 3, 2007, a complaint investigation, state licensure survey was conducted at Phillippi House. The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by November 4, 2007.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP

Supervisor

Residential Community Care Program

JS/sc

Enclosure

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED		
13R267						10/03	3/2007
NAME OF PROVIDER OR SUPPLIER  PHILLIPPI HOUSE  STREET ADD  703 S PHI BOISE, ID			LIPPI ST	TATE, ZIP CODE			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
R 000	found to be in subs Rules for Resident Facilities in Idaho. were cited during the complaint investigation	LSW veyor RN veyor	ith the Living encies nd ur facility.	R 000			
Bureau of F	acility Standards						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899 If continuation sheet 1 of 1 STATE FORM U0HJ11

TITLE



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October 15, 2007

Mariana Leahu, Administrator Phillippi House 703 S Phillippi St Boise, ID 83705

Dear Ms. Rolea:

On October 3, 2007, a complaint investigation survey was conducted at Phillippi House. The survey was conducted by Rachel Corey, RN, Donna Henscheid, LSW and Karen McDannel, RN. This report outlines the findings of our investigation.

## **Complaint # ID00002999**

Allegation #1:

Residents were left unsupervised in the facility.

Findings:

Based on observation, interview and record review it was determined that residents were left unsupervised within the facility.

Between October 1, 2007 and October 3, 2007, two random residents stated that when the administrator ran errands, an identified staff member under orientation had provided supervision to them. Record review of employee records revealed that the identified staff member had not been oriented to the facility and could thus not be supervising residents alone.

Adult protection reported that during a visit to the facility on May 3, 2007, no staff were at the facility to supervise the residents.

Conclusion:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.05 for supervision. The facility was required to submit evidence of resolution within 30 days.

Allegation #2:

The facility did not complete the appropriate background check on employees.

Findings:

Based on record review, it was determined that the facility did not complete the appropriate background check on employees.

Mariana Leahu, Administrator October 15, 2007 Page 2 of 2

Review of employee records between October 1, 2007 and October 3, 2007, revealed that two employees did not have appropriate background checks completed.

Conclusion:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.730.01 for failing to have appropriate criminal history clearance for personnel and staffing. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

DONNA HENSCHEID, LSW

Team Leader

Health Facility Surveyor

Residential Community Care Program

Donna Heuscherel

DH/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program Donna Henscheid, LSW, Health Facility Surveyor



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October 15, 2007

Mariana Leahu, Administrator Phillippi House 703 S Phillippi St Boise, ID 83705

Dear Ms. Rolea:

On October 3, 2007, a complaint investigation survey was conducted at Phillippi House. The survey was conducted by Rachel Corey, RN, Donna Henscheid, LSW and Karen McDannel, RN. This report outlines the findings of our investigation.

## **Complaint # ID00003053**

Allegation #1: The administrator was physically and mentally abusive to residents.

Findings #1: Based on observation, interview and record review it could not be determined that the administrator was physically and mentally abusive to residents.

Between October 1, 2007 and October 3, 2007, eight of eight residents were interviewed. Two residents reported being spoken harshly to and in a condescending tone, but denied that the administrator was physically or mentally abusive. One resident stated, "The administrator is stern and speaks in a loud tone of voice."

On October 1, 2007 at 1:45 p.m., a case manager for one of the residents was interviewed and stated, "The administrator is very direct with residents and needs to be when working with this population."

On October 2, 2007 at 12:00 p.m., the facility nurse stated "The administrator is up front with residents and will call a spade a spade, but she deals with the residents very well."

Conclusion #1: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation. However, the facility was issued a deficiency at IDAPA 16.03.22.550.03.b.i. for failing to treat each resident with

dignity and respect. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The administrator denied access to advocates and representatives of Protection and Advocacy.

Findings#2: Based on record review and interview, it was determined that the administrator denied access to advocates and representatives of Protection and Advocacy.

Conclusion #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.07d for not allowing access to appropriate enities. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: A resident was not given a 30 day written discharge notice.

Findings #3: Based on interview and record review it was determined the facility gave a resident a 15 day discharge notice.

On October 1, 2007 at 11:00 a.m., the administrator confirmed a resident was only given a 15 day discharge notice. She further acknowledged her admit agreement needed to be updated to reflect a 30 day discharge notice.

Conclusion #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.152 for not having a updated admission policy to meet the state rules. Further, a deficiency was cited at IDAPA 16.03.22.221.04.a-h for not providing a written notice of discharge. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: A resident was not allowed the right to retain services of health care professionals.

Findings #4: Based on interview and record review it was determined the facility did not allow health care professionals access to a resident that required skilled nursing and physical therapy services.

Conclusion #4: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.07.d for denial of access by health care professionals. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The administrator did not manage and account for the personal funds of the residents.

Findings #5: Unsubstantiated. On October 2, 2007, four residents' personal accounts were reviewed. All four records had a month by month account of each resident's funds, how the funds were dispersed and how much remained in the account after dispersal. Each resident had placed their initials on the record corresponding with the date the funds were received.

Mariana Leahu, Administrator October 15, 2007 Page 3 of 3

Conclusion #5:

Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

DONNA HENSCHEID, LSW

Donna Henscherel

Team Leader

Health Facility Surveyor

Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

Donna Henscheid, LSW, Health Facility Surveyor



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October 15, 2007

Mariana Leahu, Administrator Phillippi House 703 S Phillippi St Boise, ID 83705

Dear Ms. Rolea:

On October 3, 2007, a complaint investigation survey was conducted at Phillippi House. The survey was conducted by Rachel Corey, RN, Donna Henscheid, LSW and Karen McDannel, RN. This report outlines the findings of our investigation.

## **Complaint # ID00003067**

Allegation #1:

The administrator spoke harshly and aggressively towards a resident during the residents attempt to move out of the facility.

Findings:

Based on interviews it was determined that the administrator did not treat a resident with dignity and respect when the resident had decided to discharge from the facility.

On October 1, 2007 at 10:00 a.m., an identified resident stated that she had tried to move out of the facility and changed her mind after the administrator spoke harshly to her when she was moving out.

On October 1, 2007 at 10:32 a.m., a case manager for the identified resident stated the resident frequently changed her mind and stories. She acknowledged the administrator was firm and it could be interpreted to be aggressive by some residents.

Conclusion #1:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.03.b.i. for not treating residents in a courteous manner by staff. The facility was required to submit evidence of resolution within 30 days. Further the facility was cited at IDAPA 16.03.22.550.13 for the right to voice grievances without fear of reprisal.

Allegation #2:

An identified resident did not receive her medications on June 2nd 2007.

Mariana Leahu, Administrator October 15, 2007 Page 2 of 2

Findings:

Based on interview and record review it was determined the resident received her daily medications as prescribed by her physician.

On October 1, 2007, the facility's MAR for the identified resident was reviewed for the months of May, June, July, August, September and October 2007. The MAR had been signed that all medications had been given as scheduled and the resident confirmed she had not missed any medication.

On October 2, 2007, three random residents were interviewed and stated they had received their medications as prescribed.

Conclusion:

Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #3:

Residents were not treated with dignity and respect upon discharging from the facility.

Findings:

Based on interview it was determined the administrator did not treat the residents with respect and dignity when they requested to discharge from the facility.

On October 1, 2007 through October 3, 2007, interviews were conducted with two residents, one case manager and two PSR workers. They confirmed that when residents expressed the desire to move to another facility the administrator would get angry. She would not allow visitors or PSR workers inside the facility to help residents move out their belongings. Only current residents were allowed to help move the belongings to the outside of the facility.

Conclusion:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.03.b.i. for not respecting residents rights to discharge from the facility. The residents were not treated with dignity and respect; additionally the facility was cited at IDAPA 16.03.22.550.07.d for not allowing visitors to enter the facility. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

DONNA HENSCHEID. LSW

Team Leader

Health Facility Surveyor

Residential Community Care Program

Donna Klenschreid

DH/sc

c:

Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program



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October 15, 2007

Mariana Leahu, Administrator Phillippi House 703 S Phillippi Street Boise, ID 83705

Dear Ms. Rolea:

On October 3, 2007, a complaint investigation survey was conducted at Phillippi House. The survey was conducted by Rachel Corey, RN, Donna Henscheid, LSW and Karen McDannel, RN. This report outlines the findings of our investigation.

## **Complaint # ID00003096**

Allegation #1:

The administrator had sexually molested an identified resident.

Findings:

Based on interview and record review, it could not be determined that the administrator had sexually molested an identified resident.

Between October 1, 2007 and October 3, 2007, the identified resident stated during several interviews that the administrator assisted her with bathing and pericare. She denied being sexually molested but stated the assistance with bathing was more extensive than she desired. She further expressed a desire to be given the opportunity to be more independent with bathing.

Between October 1, 2007 and October 3, 2007 during interviews, the resident's caseworker and PSR worker confirmed that the resident did need assistance with bathing to ensure cleanliness, but agreed that she could be given more independence in personal hygiene tasks.

Conclusion:

Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation. However, the facility was issued a deficiency at IDAPA 16.03.22.550.03.b.i for failing to respect the resident's dignity and respect. The facility was required to submit evidence of resolution within 30 days.

Mariana Leahu, Administrator October 15, 2007 Page 2 of 2

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

DONNA HENSCHEID, LSW

Donna Henscheiel

Team Leader

Health Facility Surveyor

Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

Donna Henscheid, LSW, Health Facility Surveyor



ASSISTED LIVING Non-Core Issues Punch List

Facility		. 1	Physical Address	/ Phone Number		
	Phillippi strator	House	703 S. Phillippi S	St. 208.	342 - 6739	***
Adminis	strator	1	City	ZIP Code		
	Marian	a Leahu	Boise		3705	
Survey			Survey Type	Survey Date }	_ 1	***************************************
	Donna	Henscheid	Standard / Complaint	101	3/07	
NON	-CORE ISSU	ES				
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/	1/4/07[			•		



**ASSISTED LIVING** Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Phillippi House	763 S. Phillippi St.	208-342-0739
Administrator	City .	ZIP Code
Mariana Leahu	Boise	83705
Survey Team Leader	Survey Type	Survey Date / /
. Donna Henscheid	Stundard (Complaint	10/3/07
NON-CORE ISSUES		/

Survey 7	Team Leader	1/1 -/	Survey Type	10 1.1	Survey Date	1 ====	
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	14/07	/					
BFS-68	36 March 2006	M: Nolia	mple section 1			9/	′04



**ASSISTED LIVING** Non-Core Issues Punch List

Facility Name	pi Huse	Physical Address  703 S. Phillippi St.	Phone Number 208-342-6739		
	ana Leahu	Bobe	21P Code \$ 3705		
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ASSISTED LIVING Non-Core Issues Punch List

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Facility	Name		Physical Address	Phone Number		
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Adminis	strator / /		City /2	ZIP Čode		
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